
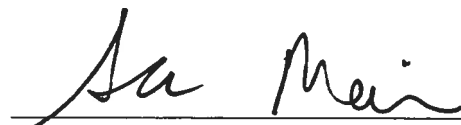


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Emily B Caudill
REGULATIONS COMPILER

STATEMENT OF EMERGENCY
907 KAR 15:022E

This emergency administrative regulation is being promulgated to implement state and federal enhancements to services provided by behavioral health services organizations. This emergency administrative regulation is needed pursuant to KRS 13A.190(1)(a)1. to meet an imminent threat to public health and pursuant to KRS 13A.190(1)(a)2. to prevent a loss of federal funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is not identical to this emergency administrative regulation as this emergency administrative regulation refers to the effective date of the ordinary administrative regulation in establishing a sunset date for temporary licensure for certified alcohol and drug counselors working within a narcotic treatment program (in Section 3(7)(q)6.d.(i)) and includes an additional Section 14 to establish an implementation date of July 1, 2019 for the entire administrative regulation.


Matthew G. Bevin
Governor


Adam M. Meier, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (New Emergency Administrative Regulation)

5 907 KAR 15:022E. Coverage provisions and requirements regarding services provided by be-
6 havioral health services organizations for substance use disorder treatment and co-occurring dis-
7 orders.

8 RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 1396a(a)(23), 12101

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Ser-
11 vices, Department for Medicaid Services, has a responsibility to administer the Medicaid Pro-
12 gram. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any
13 requirement that may be imposed or opportunity presented by federal law to qualify for federal
14 Medicaid funds. This administrative regulation establishes the coverage provisions and require-
15 ments regarding Medicaid Program behavioral health services provided by tier II and III behav-
16 ioral health services organizations.

17 Section 1. General Coverage Requirements. (1) For the department to reimburse for a service
18 covered under this administrative regulation, the service shall be:

19 (a) Medically necessary; and

20 (b) Provided:

21 1. To a recipient; and

1 2. By a behavioral health services organization that meets the provider participation require-
2 ments established in Section 2 of this administrative regulation.

3 (2)(a) Direct contact between a practitioner and a recipient shall be required for each service
4 except for:

5 1. Collateral outpatient therapy for a child under the age of twenty-one (21) years if the collat-
6 eral outpatient therapy is in the child's plan of care;

7 2. A family outpatient service in which the corresponding current procedural terminology
8 code establishes that the recipient is not present; or

9 3. A psychological testing service comprised of interpreting or explaining results of an exam-
10 ination or data to family members or other kin if the corresponding current procedural terminol-
11 ogy code establishes that the recipient is not present.

12 (b) A service that does not meet the requirement in paragraph (a) of this subsection shall not
13 be covered.

14 (3) A billable unit of service shall be actual time spent delivering a service in an encounter.

15 (4) A service shall be:

16 (a) Stated in the recipient's plan of care; and

17 (b) Provided in accordance with the recipient's plan of care.

18 (5)(a) A behavioral health services organization shall establish a plan of care for each recipi-
19 ent receiving services from the behavioral health services organization.

20 (b) A plan of care shall meet the plan of care requirements established in 908 KAR 1:370,
21 Section 19.

22 Section 2. Provider Participation. (1) To be eligible to provide services under this administra-
23 tive regulation, a behavioral health services organization shall:

1 (a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR
2 1:672;

3 (b) ~~[Except as established in subsection (2) of this section,]~~ Be currently participating in the
4 Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

5 (c) Have:

6 1. For each service it provides, the capacity to provide the full range of the service as estab-
7 lished in this administrative regulation;

8 2. Documented experience in serving individuals with substance use disorders;

9 3. The administrative capacity to ensure quality of services;

10 4. A financial management system that provides documentation of services and costs; and

11 5. The capacity to document and maintain individual case records.

12 (2) A behavioral health services organization shall:

13 (a) Agree to provide services in compliance with federal and state laws regardless of age, sex,
14 race, creed, religion, national origin, handicap, or disability;

15 (b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any
16 amendments to the Act; and

17 (c) Provide, directly or through written agreement with another behavioral health services
18 provider, access to face-to-face or telehealth, as appropriate pursuant to 907 KAR 3:170, emer-
19 gency services twenty-four (24) hours per day, seven (7) days per week.

20 (3)(a) Each behavioral health services organization II (BHSO II) shall provide services in ac-
21 cordance with 908 KAR 1:374 and this administrative regulation for outpatient substance use
22 disorder services and co-occurring disorders.

23 (b) Each behavioral health services organization III (BHSO III) shall provide services in ac-

1 cordance with 908 KAR 1:372 and this administrative regulation for residential substance use
2 disorder services and co-occurring disorders.

3 (4) A BHSO II shall:

4 (a) Possess an outpatient alcohol and other drug treatment entity (AODE) license issued pur-
5 suant to 908 KAR 1:370 and 908 KAR 1:374;

6 (b) Possess accreditation within one (1) year of initial enrollment by one (1) of the following:

7 1. The Joint Commission;

8 2. The Commission on Accreditation of Rehabilitation Facilities;

9 3. The Council on Accreditation; or

10 4. A nationally recognized accreditation organization; and

11 (c) Be authorized to provide outpatient substance use disorder treatment services authorized
12 by Section 3 of this administrative regulation to treat substance use disorders and co-occurring
13 disorders by the appropriate provider.

14 (5) A BHSO III shall:

15 (a) Possess a residential alcohol and other drug treatment entity (AODE) license issued pursu-
16 ant to 908 KAR 1:370 and 908 KAR 1:372;

17 (b) Possess accreditation within one (1) year of initial enrollment by one (1) of the following:

18 1. The Joint Commission;

19 2. The Commission on Accreditation of Rehabilitation Facilities;

20 3. The Council on Accreditation; or

21 4. A nationally recognized accreditation organization; and

22 (c) Be authorized to provide residential substance use disorder treatment services authorized
23 by Section 3 of this administrative regulation to treat substance use disorders and co-occurring

disorders by the appropriate provider.

Section 3. Covered Services.

(1)(a) A physician providing services in a BHSO II shall possess:

1. A psychiatric specialty; or
2. An addictionology specialty.

(b) An advanced practice registered nurse providing services in a BHSO II shall possess:

1. A psychiatric specialty; or
2. An addictionology specialty.

(c) A physician assistant providing behavioral health services in a BHSO II shall have a contractual relationship with a supervising physician with:

1. A psychiatric specialty; or
2. An addictionology specialty.

(2) Reimbursement shall not be available for services performed within a BHSO II by a:

- (a) Licensed behavior analyst;
- (b) Licensed assistant behavior analyst;
- (c) Registered behavioral technician; or
- (d) Community support associate.

(3) A BHSO III shall provide services on a residential basis to treat a beneficiary's substance use disorder.

(4)(a) A physician providing services in a BHSO III shall possess:

1. A psychiatric specialty; or
2. An addictionology specialty.

(b) An advanced practice registered nurse providing services in a BHSO III shall possess:

1. A psychiatric specialty; or

2. An addictionology specialty.

(c) A physician assistant providing behavioral health services in a BHSO III shall have a contractual relationship with a supervising physician with:

1. A psychiatric specialty; or

2. An addictionology specialty.

(5) Reimbursement shall not be available for services performed within a BHSO III by a:

(a) Licensed behavior analyst;

(b) Licensed assistant behavior analyst;

(c) Registered behavioral technician; or

(d) Community support associate.

(6) Except as specified in the requirements stated for a given service, the services covered may be provided for:

(a) A substance use disorder; or

(b) Co-occurring disorders if provided in accordance with Section 2 of this administrative regulation.

(7) The services established in this subsection shall be covered under this administrative regulation in accordance with the requirements established in this subsection.

(a) A screening shall:

1. Determine the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorders;

2. Not establish the presence or specific type of disorder;

3. Establish the need for an in-depth assessment;

1 4. Be face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and

2 5. In a BHSO II, be provided by:

3 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
4 section; or

5 b. An approved behavioral health practitioner under supervision, as limited by subsections (2)
6 and (5) of this section.

7 (b) An assessment shall:

8 1. Include gathering information and engaging in a process with the individual that enables
9 the practitioner to:

10 a. Establish the presence or absence of a substance use disorder or co-occurring disorders;

11 b. Determine the individual's readiness for change;

12 c. Identify the individual's strengths or problem areas that may affect the treatment and recov-
13 ery processes; and

14 d. Engage the individual in developing an appropriate treatment relationship;

15 2. Establish or rule out the existence of a clinical disorder or service need;

16 3. Include working with the individual to develop a plan of care;

17 4. Not include a psychological or psychiatric evaluation or assessment;

18 5. If being made for the treatment of a substance use disorder, utilize a multidimensional as-
19 sessment that complies with the most current edition of The ASAM Criteria to determine the
20 most appropriate level of care;

21 6. Be face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and

22 7. Be provided by:

23 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this

1 section; or

2 b. An approved behavioral health practitioner under supervision, except for a certified alcohol
3 and drug counselor, and as limited by subsections (2) and (5) of this section.

4 (c) Psychological testing shall:

5 1. Include a psychodiagnostic assessment of personality, psychopathology, emotionality, or
6 intellectual disabilities;

7 2. Include an interpretation and a written report of testing results;

8 3. Be face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and

9 4. Be provided by:

10 a. A licensed psychologist;

11 b. A certified psychologist with autonomous functioning;

12 c. A licensed psychological practitioner;

13 d. A certified psychologist under supervision; or

14 e. A licensed psychological associate under supervision.

15 (d) Crisis intervention:

16 1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating
17 the risk of physical or emotional harm to:

18 a. The recipient; or

19 b. Another individual;

20 2. Shall consist of clinical intervention and support services necessary to provide integrated
21 crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;

22 3. Shall be provided:

23 a. On-site at the behavioral health services organization's office;

1 b. As an immediate relief to the presenting problem or threat; and

2 c. In a face-to-face, one (1) on one (1) encounter between the provider and the recipient, in-
3 cluding via telehealth if appropriate pursuant to 907 KAR 3:170;

4 4. Shall be followed by a referral to non-crisis services if applicable;

5 5. May include:

6 a. Further service prevention planning including:

7 (i) Lethal means reduction for suicide risk; or

8 (ii) Substance use disorder relapse prevention; or

9 b. Verbal de-escalation, risk assessment, or cognitive therapy; and

10 6. Shall be provided by:

11 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
12 section; or

13 b. An approved behavioral health practitioner under supervision, as limited by subsections (2)
14 and (5) of this section.

15 (e) Mobile crisis services shall:

16 1. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year;

17 2. Be provided for a duration of less than twenty-four (24) hours;

18 3. Not be an overnight service;

19 4. Be a face-to-face or telehealth, as appropriate pursuant to 907 KAR 3:170, multi-
20 disciplinary team based intervention in a home or community setting that ensures access to sub-
21 stance use disorder and co-occurring disorder services and supports to:

22 a. Reduce symptoms or harm; or

23 b. Safely transition an individual in an acute crisis to the appropriate least restrictive level of

- 1 care;
- 2 5. Involve all services and supports necessary to provide:
- 3 a. Integrated crisis prevention;
- 4 b. Assessment and disposition;
- 5 c. Intervention;
- 6 d. Continuity of care recommendations; and
- 7 e. Follow-up services;
- 8 6. Include access to a board-certified or board-eligible psychiatrist twenty-four (24) hours a
- 9 day, seven (7) days a week, every day of the year; and
- 10 7. Be provided by:
- 11 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
- 12 section;
- 13 b. An approved behavioral health practitioner under supervision, except for a certified alcohol
- 14 and drug counselor, and as limited by subsections (2) and (5) of this section; or
- 15 c. A peer support specialist who:
- 16 (i) Is under the supervision of an approved behavioral health practitioner; and
- 17 (ii) Provides support services for a mobile crisis service.
- 18 (f)1. Day treatment shall be a non-residential, intensive treatment program for a child under
- 19 the age of twenty-one (21) years who has:
- 20 a. A substance use disorder or co-occurring disorders; and
- 21 b. A high risk of out-of-home placement due to a behavioral health issue.
- 22 2. Day treatment shall:
- 23 a. Be face-to-face;

1 b. Consist of an organized, behavioral health program of treatment and rehabilitative services;

2 c. Include:

3 (i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

4 (ii) Behavior management and social skills training;

5 (iii) Independent living skills that correlate to the age and developmental stage of the recipi-
6 ent; or

7 (iv) Services designed to explore and link with community resources before discharge and to
8 assist the recipient and family with transition to community services after discharge; and

9 d. Be provided:

10 (i) In collaboration with the education services of the local education authority including those
11 provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29
12 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);

13 (ii) On school days and during scheduled school breaks;

14 (iii) In coordination with the recipient's individualized education program or Section 504 plan
15 if the recipient has an individualized education program or Section 504 plan;

16 (iv) Under the supervision of an approved behavioral health practitioner or an approved be-
17 havioral health practitioner under supervision, as limited by subsections (2) and (5) of this sec-
18 tion; and

19 (v) With a linkage agreement with the local education authority that specifies the responsibili-
20 ties of the local education authority and the day treatment provider.

21 3. To provide day treatment services, a behavioral health services organization shall have:

22 a. The capacity to employ staff authorized to provide day treatment services in accordance
23 with this section and to coordinate the provision of services among team members; and

b. Knowledge of substance use disorders and co-occurring disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education program or Section 504 plan.

5. Day treatment shall be provided by:

a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this section; or

b. An approved behavioral health practitioner under supervision, except for a certified alcohol and drug counselor, and as limited by subsections (2) and (5) of this section.

6. Day treatment support services conducted by a provider working under the supervision of an approved behavioral health practitioner may be provided by:

a. A registered alcohol and drug peer support specialist;

b. An adult peer support specialist;

c. A family peer support specialist; or

d. A youth peer support specialist.

(g)1. Peer support services shall:

a. Be emotional support that is provided by:

(i) An individual who has been trained and certified in accordance with 908 KAR 2:220 and who is experiencing or has experienced a substance use disorder or co-occurring disorders to a recipient by sharing a similar substance use disorder or co-occurring disorders in order to bring about a desired social or personal change;

(ii) A parent or other family member, who has been trained and certified in accordance with 908 KAR 2:230, of a child having or who has had a substance use or co-occurring disorders to a parent or family member of a child sharing a similar substance use or co-occurring disorders in

1 order to bring about a desired social or personal change;

2 (iii) An individual who has been trained and certified in accordance with 908 KAR 2:240 and
3 identified as experiencing a substance use disorder or co-occurring disorders, as defined in the
4 current version of the Diagnostic and Statistical Manual for Mental Disorders; or

5 (iv) A registered alcohol and drug peer support specialist who has been trained and certified in
6 accordance with KRS 309.0831 and is a self-identified consumer of substance use disorder ser-
7 vices who provides emotional support to others with substance use disorders to achieve a desired
8 social or personal change;

9 b. Be an evidence-based practice;

10 c. Be structured and scheduled non-clinical therapeutic activities with an individual recipient
11 or a group of recipients;

12 d. Be provided face-to-face;

13 e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of commu-
14 nity living skills for the recipient;

15 f. Except for the engagement into substance use disorder treatment through an emergency de-
16 partment bridge clinic, be coordinated within the context of a comprehensive, individualized plan
17 of care developed through a person-centered planning process;

18 g. Be identified in each recipient's plan of care; and

19 h. Be designed to directly contribute to the recipient's individualized goals as specified in the
20 recipient's plan of care.

21 2. To provide peer support services, a behavioral health services organization shall:

22 a. Have demonstrated:

23 (i) The capacity to provide peer support services for the behavioral health population being

- 1 served including the age range of the population being served; and
- 2 (ii) Experience in serving individuals with behavioral health disorders;
- 3 b. Employ peer support specialists who are qualified to provide peer support services in ac-
- 4 cordance with 908 KAR 2:220, 908 KAR 2:230, 908 KAR 2:240, or KRS 309.0831;
- 5 c. Use an approved behavioral health practitioner to supervise peer support specialists;
- 6 d. Have the capacity to coordinate the provision of services among team members;
- 7 e. Have the capacity to provide on-going continuing education and technical assistance to peer
- 8 support specialists;
- 9 f. Require individuals providing peer support services to recipients provide no more than 120
- 10 units per week of direct recipient contact; and
- 11 g. Require peer support services provided to recipients in a group setting not exceed eight (8)
- 12 individuals within any group at one (1) time.
- 13 (h)1. Intensive outpatient program services shall:
- 14 a. Be an alternative to or transition from a higher level of care for a substance use disorder or
- 15 co-occurring disorders;
- 16 b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is sig-
- 17 nificantly more intensive than individual outpatient therapy, group outpatient therapy, or family
- 18 outpatient therapy;
- 19 c. Meet the service criteria, including the components for support systems, staffing, and thera-
- 20 pies outlined in the most current edition of The ASAM Criteria for intensive outpatient level of
- 21 care services;
- 22 d. Be provided face-to-face;
- 23 e. Be provided at least three (3) hours per day at least three (3) days per week for adults;

1 f. Be provided at least six (6) hours per week for adolescents; and

2 g. Include:

3 (i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless
4 contraindicated;

5 (ii) Crisis intervention; or

6 (iii) Psycho-education related to identified goals in the recipient's treatment plan.

7 2. During psycho-education, the recipient or recipient's family member shall be:

8 a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition,
9 and the reasons why a particular treatment might be effective for reducing symptoms; and

10 b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

11 3. An intensive outpatient program services treatment plan shall:

12 a. Be individualized; and

13 b. Focus on stabilization and transition to a lesser level of care.

14 4. To provide intensive outpatient program services, a behavioral health services organization
15 shall have:

16 a. Access to a board-certified or board-eligible psychiatrist for consultation;

17 b. Access to a psychiatrist, physician, or advanced practiced registered nurse for medication
18 prescribing and monitoring;

19 c. Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients to one
20 (1) staff person;

21 d. The capacity to provide services utilizing a recognized intervention protocol based on na-
22 tionally accepted treatment principles; and

23 e. The capacity to employ staff authorized to provide intensive outpatient program services in

1 accordance with this section and to coordinate the provision of services among team members.

2 5. Intensive outpatient program services shall be provided by:

3 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
4 section; or

5 b. An approved behavioral health practitioner under supervision, as limited by subsections (2)
6 and (5) of this section.

7 (i) Individual outpatient therapy shall:

8 1. Be provided to promote the:

9 a. Health and wellbeing of the individual; and

10 b. Restoration of a recipient to their best possible functional level from a substance use disor-
11 der or co-occurring disorders;

12 2. Consist of:

13 a. A face-to-face encounter or via telehealth as appropriate pursuant to 907 KAR 3:170 that is
14 a one (1) on one (1) encounter between the provider and recipient; and

15 b. A behavioral health therapeutic intervention provided in accordance with the recipient's
16 identified plan of care;

17 3. Be aimed at:

18 a. Reducing adverse symptoms;

19 b. Reducing or eliminating the presenting problem of the recipient; and

20 c. Improving functioning;

21 4. Not exceed three (3) hours per day alone or in combination with any other outpatient thera-
22 py per recipient unless additional time is medically necessary; and

23 5. Be provided by:

1 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
2 section; or

3 b. An approved behavioral health practitioner under supervision, except for a certified alcohol
4 and drug counselor, and as limited by subsections (2) and (5) of this section.

5 (j)1. Group outpatient therapy shall:

6 a. Be a behavioral health therapeutic intervention provided in accordance with a recipient's
7 identified plan of care;

8 b. Be provided to promote the:

9 (i) Health and wellbeing of the individual; and

10 (ii) Restoration of a recipient to their best possible functional level from a substance use dis-
11 order or co-occurring disorders;

12 c. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance
13 with the recipient's identified plan of care;

14 d. Be provided to a recipient in a group setting:

15 (i) Of nonrelated individuals except for multi-family group therapy; and

16 (ii) Not to exceed twelve (12) individuals in size;

17 e. Focus on the psychological needs of the recipients as evidenced in each recipient's plan of
18 care;

19 f. Center on goals including building and maintaining healthy relationships, personal goals
20 setting, and the exercise of personal judgment;

21 g. Not include physical exercise, a recreational activity, an educational activity, or a social ac-
22 tivity; and

23 h. Not exceed three (3) hours per day alone or in combination with any other outpatient thera-

py per recipient unless additional time is medically necessary.

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of group outpatient therapy shall relate to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

5. Group outpatient therapy shall be provided by:

a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this section; or

b. An approved behavioral health practitioner under supervision, except for a certified alcohol and drug counselor, and as limited by subsections (2) and (5) of this section.

(k)1. Family outpatient therapy shall consist of a face-to-face or appropriate telehealth, pursuant to 907 KAR 3:170, behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

3. Family outpatient therapy shall:

1 a. Be provided to promote the:

2 (i) Health and wellbeing of the individual; or

3 (ii) Restoration of a recipient to their best possible functional level from a substance use dis-
4 order or co-occurring disorders; and

5 b. Not exceed three (3) hours per day alone or in combination with any other outpatient thera-
6 py per recipient unless additional time is medically necessary.

7 4. Family outpatient therapy shall be provided by:

8 a. An approved behavioral health practitioner; or

9 b. An approved behavioral health practitioner under supervision, except for a certified alcohol
10 and drug counselor.

11 (l)1. Collateral outpatient therapy shall:

12 a. Consist of a face-to-face or appropriate telehealth, provided pursuant to 907 KAR 3:170,
13 behavioral health consultation:

14 (i) With a parent or caregiver of a recipient, household member of a recipient, legal repre-
15 sentative of a recipient, school personnel, treating professional, or other person with custodial
16 control or supervision of the recipient; and

17 (ii) That is provided in accordance with the recipient's plan of care; and

18 b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of
19 age.

20 2. Written consent by a parent or custodial guardian to discuss a recipient's treatment with
21 any person other than a parent or legal guardian shall be signed and filed in the recipient's health
22 record.

23 3. Collateral outpatient therapy shall be provided by:

1 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
2 section; or

3 b. An approved behavioral health practitioner under supervision, except for a certified alcohol
4 and drug counselor, and as limited by subsections (2) and (5) of this section.

5 (m)1. Service planning shall:

6 a. Be provided face-to-face;

7 b. Involve assisting a recipient in creating an individualized plan for services and developing
8 measurable goals and objectives needed for maximum reduction of the effects of a substance use
9 disorder or co-occurring disorders;

10 c. Involve restoring a recipient's functional level to the recipient's best possible functional lev-
11 el; and

12 d. Be performed using a person-centered planning process.

13 2. A service plan:

14 a. Shall be directed and signed by the recipient;

15 b. Shall include practitioners of the recipient's choosing; and

16 c. May include:

17 (i) A mental health advance directive being filed with a local hospital;

18 (ii) A crisis plan; or

19 (iii) A relapse prevention strategy or plan.

20 3. Service planning shall be provided by:

21 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
22 section; or

23 b. An approved behavioral health practitioner under supervision, except for a certified alcohol

and drug counselor, and as limited by subsections (2) and (5) of this section.

(n)1. Residential services for substance use disorders shall:

a. Be provided in a twenty-four (24) hour per day unit that is a live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring disorders;

b. Provide intensive treatment and skills building in a structured and supportive environment;

c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;

d. Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free;

e. Be provided under the medical direction of a physician;

f. Provide continuous nursing services in which a registered nurse shall be:

(i) On-site during traditional first shift hours, Monday through Friday;

(ii) Continuously available by phone after hours; and

(iii) On-site as needed in follow-up to telephone consultation after hours;

g. Be provided following an assessment of an individual and a determination that the individual meets the dimensional admission criteria for approval of residential level of care placement in accordance with the most current edition of The ASAM Criteria; and

h. Be based on individual need and shall include clinical activities to help the recipient develop and apply recovery skills.

2. Residential services may include:

a. A screening;

b. An assessment;

- c. Service planning;
- d. Individual outpatient therapy;
- e. Group outpatient therapy;
- f. Family outpatient therapy;
- g. Peer support;
- h. Withdrawal management; or
- i. Medication assisted treatment.

3. For recipients in residential substance use treatment, care coordination shall include at minimum:

- a. If the recipient chooses medication assisted treatment, facilitation of medication assisted treatment off-site of the BHSO III, if not offered on-site;
- b. Referral to appropriate community services;
- c. Facilitation of medical and behavioral health follow ups; and
- d. Linking the recipient to the appropriate level of substance use treatment within the continuum to provide ongoing supports.

4. Residential services shall be provided in accordance with 908 KAR 1:370 and 908 KAR 1:372.

5. Length-of-stay for residential services for substance use disorders shall be person-centered and according to an individually designed plan of care that is consistent with this administrative regulation and the licensure of the facility and practitioner.

6.a. Except as established in clause b. of this subparagraph, the physical structure in which residential services for substance use disorders is provided shall:

- (i) Have between nine (9) and sixteen (16) beds; and

1 (ii) Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds
2 in aggregate.

3 b. If every recipient receiving services in the physical structure is under the age of twenty-one
4 (21) years or over the age of sixty-five (65) years, the limit of sixteen (16) beds established in
5 clause a. of this subparagraph shall not apply.

6 7. Residential services for substance use disorders shall not include:

7 a. Room and board;

8 b. Educational services;

9 c. Vocational services;

10 d. Job training services;

11 e. Habilitation services;

12 f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

13 g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R.
14 435.1010;

15 h. Recreational activities;

16 i. Social activities; or

17 j. Services required to be covered elsewhere in the Medicaid state plan.

18 8. To provide residential services for substance use disorders, a behavioral health services or-
19 ganization shall:

20 a. Have the capacity to employ staff authorized to provide services in accordance with this
21 section and to coordinate the provision of services among team members; and

22 b. Be licensed as a non-medical and non-hospital based alcohol and other drug abuse treat-
23 ment entity in accordance with 908 KAR 1:370 and 908 KAR 1:372.

1 9. A BHSO III may provide residential services for substance use disorders, if provided by:

2 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
3 section; or

4 b. An approved behavioral health practitioner under supervision, as limited by subsections (2)
5 and (5) of this section.

6 10. Support services for residential services for substance use disorders may be provided by a
7 peer support specialist under the supervision of an approved behavioral health practitioner.

8 (o)1. Screening, brief intervention, and referral to treatment for a substance use disorder shall:

9 a. Be provided face-to-face;

10 b. Be an evidence-based early intervention approach for an individual with non-dependent
11 substance use to provide an effective strategy for intervention prior to the need for more exten-
12 sive or specialized treatment; and

13 c. Consist of:

14 (i) Using a standardized screening tool to assess an individual for risky substance use behav-
15 ior;

16 (ii) Engaging a recipient, who demonstrates risky substance use behavior, in a short conversa-
17 tion and providing feedback and advice; and

18 (iii) Referring a recipient to additional substance use disorder or co-occurring disorder ser-
19 vices if the recipient is determined to need additional services to address substance use.

20 2. A screening and brief intervention that does not meet criteria for referral to treatment may
21 be subject to coverage by the department.

22 3. A screening, brief intervention, and referral to treatment for a substance use disorder shall
23 be provided by:

1 a. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
2 section; or

3 b. An approved behavioral health practitioner under supervision, as limited by subsections (2)
4 and (5) of this section.

5 (p)1. Withdrawal management services shall:

6 a. Be provided face-to-face for recipients with a substance use disorder or co-occurring disor-
7 ders;

8 b. Be incorporated into a recipient's care as appropriate according to the continuum of care
9 described in the most current version of The ASAM Criteria;

10 c. Be in accordance with the most current version of The ASAM Criteria for withdrawal man-
11 agement levels in an outpatient setting;

12 d. If provided in an outpatient setting, comply with 908 KAR 1:374, Section 2; and

13 e. If provided in a substance use disorder residential program, comply with 908 KAR 1:372,
14 Section 2.

15 2. A recipient who is receiving withdrawal management services shall:

16 a. Meet the most current edition of diagnostic criteria for substance withdrawal management
17 found in the Diagnostic and Statistical Manual of Mental Disorders; and

18 b. Meet the current dimensional admissions criteria for withdrawal management level of care
19 as found in The ASAM Criteria.

20 3. Withdrawal management services shall be provided by:

21 a. A physician;

22 b. A psychiatrist;

23 c. A physician assistant;

1 d. An advanced practice registered nurse; or

2 e. Any other approved behavioral health practitioner with oversight by a physician, advanced
3 practice registered nurse, or a physician assistant, as limited by subsections (2) and (5) of this
4 section.

5 (q)1. Medication assisted treatment services shall be provided by an authorized prescribing
6 provider who:

7 a.(i) Is a physician licensed to practice medicine under KRS Chapter 311; or

8 (ii) Is an advanced practice registered nurse (APRN);

9 b. Meets standards in accordance with 201 KAR 9:270 or 201 KAR 20:065;

10 c. Maintains a current waiver under 21 U.S.C. 823(g)(2) to prescribe buprenorphine products;

11 and

12 d. Has experience and knowledge in addiction medicine.

13 2. Medication assisted treatment with behavioral health therapies shall:

14 a. Be co-located within the same practicing site or via telehealth as appropriate according to
15 907 KAR 3:170 as the practitioner with a waiver pursuant to subparagraph 1.c. of this paragraph;
16 or

17 b. Be conducted with agreements in place for linkage to appropriate behavioral health treat-
18 ment providers who specialize in substance use disorders and are knowledgeable in biopsychosocial
19 dimensions of alcohol or other substance use disorder, such as:

20 (i) An approved behavioral health practitioner, as limited by subsections (2) and (5) of this
21 section; or

22 (ii) A multi-specialty group or behavioral health provider group pursuant to 907 KAR 15:010.

23 3. Medication assisted treatment may be provided in:

1 a. An outpatient behavioral health setting, including in a narcotic treatment program for sub-
2 stance use disorder treatment with methadone operating in accordance with 908 KAR 1:374,
3 Section 7; or

4 b. A residential treatment program for substance use disorders. If a residential treatment pro-
5 gram for substance use disorders does not offer medication assisted treatment on-site, care coor-
6 dination shall be provided to facilitate medication assisted treatment off-site if necessary by re-
7 cipient choice.

8 4. A medication assisted treatment program shall:

9 a. Assess the need for treatment including:

10 (i) A full patient history to determine the severity of the patient's substance use disorder; and

11 (ii) Identifying and addressing any underlying or co-occurring diseases or conditions, as nec-
12 essary;

13 b. Educate the patient about how the medication works, including:

14 (i) The associated risks and benefits; and

15 (ii) Overdose prevention;

16 c. Evaluate the need for medically managed withdrawal from substances;

17 d. Refer patients for higher levels of care if necessary; and

18 e. Obtain informed consent prior to integrating pharmacologic or nonpharmacologic therapies.

19 5. Medication assisted treatment shall be provided by:

20 a. A physician;

21 b. A psychiatrist; or

22 c. An advanced practice registered nurse.

23 6.a. Notwithstanding any other provision of 907 KAR Chapter 15 to the contrary, temporary

1 licensure shall be permissible for a certified alcohol and drug counselor practicing within a nar-
2 cotic treatment program.

3 b. A temporarily certified alcohol and drug counselor practicing within a narcotic treatment
4 program shall be under the direct supervision of a licensed clinical alcohol and drug counselor.

5 c. A temporarily certified alcohol and drug counselor pursuant to this subparagraph shall pro-
6 vide only the following services:

7 (i) Individual counseling;

8 (ii) Group counseling; and

9 (iii) Targeted case management pursuant to 907 KAR 15:040 and 907 KAR 15:050.

10 d.(i) The provisions of this subparagraph shall no longer be operational two (2) years after the
11 effective date of the ordinary administrative regulation filed simultaneously with this emergency
12 administrative regulation.

13 (ii) After the two (2) year period has lapsed, an individual performing temporarily licensed
14 certified alcohol and drug counselor duties as specified in clause c. of this subparagraph shall
15 possess an appropriate license to perform those duties.

16 (r)1. Partial hospitalization services shall be:

17 a. Short-term with an average of four (4) to six (6) weeks,

18 b. Less than twenty-four (24) hours each day; and

19 c. An intensive treatment program for an individual who is experiencing significant impair-
20 ment to daily functioning due to a substance use disorder or co-occurring disorders.

21 2. Partial hospitalization may be provided to an adult or a minor.

22 3. Admission criteria for partial hospitalization shall be based on an inability of community-
23 based therapies or intensive outpatient services to adequately treat the recipient.

1 4. A partial hospitalization program shall meet the service criteria, including the components
2 for support systems, staffing, and therapies outlined in the most current edition of The ASAM
3 Criteria for partial hospitalization level of care services.

4 5. A partial hospitalization program shall consist of:

- 5 a. Individual outpatient therapy;
- 6 b. Group outpatient therapy;
- 7 c. Family outpatient therapy; or
- 8 d. Medication management.

9 6. The department shall not reimburse for educational, vocational, or job training services
10 provided as part of partial hospitalization.

11 7.a. A behavioral health services organization's partial hospitalization program shall have an
12 agreement with the local educational authority to come into the program to provide all educa-
13 tional components and instruction that are not Medicaid billable or reimbursable.

14 b. Services in a Medicaid eligible child's individualized education program shall be coverable
15 under Medicaid.

16 8. Partial hospitalization shall be:

- 17 a. Provided for at least four (4) hours per day; and
- 18 b. Focused on one (1) primary presenting problem.

19 9. A partial hospitalization program operated by a behavioral health services organization
20 shall:

21 a. Include the following personnel for the purpose of providing medical care:

22 (i) An advanced practice registered nurse, a physician assistant, or a physician available on
23 site; and

(ii) A board-certified or board-eligible psychiatrist available for consultation; and

b. Have the capacity to:

(i) Provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles;

(ii) Employ required practitioners and coordinate service provision among rendering practitioners; and

(iii) Provide the full range of services included in the scope of partial hospitalization established in this paragraph.

(8)(a) Limited laboratory services shall be reimbursable in accordance with 907 KAR 1:028 if provided by a BHSO II or a BHSO III if:

1. The BHSO II or BHSO III has the appropriate CLIA certificate to perform laboratory testing pursuant to 907 KAR 1:028; and

2. The services are prescribed by a physician, advanced practice registered nurse, or physician assistant who has a contractual relationship with the BHSO II or BHSO III.

(b) Limited laboratory services shall be administered, as appropriate, by:

1. An approved behavioral health practitioner, as limited by subsections (2) and (5) of this section; or

2. An approved behavioral health practitioner under supervision, as limited by subsections (2) and (5) of this section.

Section 4. Additional Limits and Non-covered Services or Activities. (1)(a) Except as established in paragraph (b) of this subsection, unless a diagnosis is made and documented in the recipient's medical record within three (3) visits, the service shall not be covered.

(b) The requirement established in paragraph (a) of this subsection shall not apply to:

1 1. Mobile crisis services;
2 2. Crisis intervention;
3 3. A screening;
4 4. An assessment; or
5 5. Peer support services for the engagement into substance use disorder treatment within an
6 emergency department bridge clinic.

7 (2) For a recipient who is receiving residential services for a substance use disorder, the fol-
8 lowing shall not be billed or reimbursed for the same date of service for the recipient:

- 9 (a) A screening;
- 10 (b) An assessment;
- 11 (c) Service planning;
- 12 (d) A psychiatric service;
- 13 (e) Individual outpatient therapy;
- 14 (f) Group outpatient therapy;
- 15 (g) Family outpatient therapy; or
- 16 (h) Peer support services.

17 (3) For a recipient who is receiving assertive community treatment for non-substance use dis-
18 order treatment pursuant to 907 KAR 15:020, the following shall not be billed or reimbursed for
19 the same date of service for the recipient:

- 20 (a) An assessment;
- 21 (b) Case management;
- 22 (c) Individual outpatient therapy;
- 23 (d) Group outpatient therapy;

1 (e) Peer support services; or

2 (f) Mobile crisis services.

3 (4) The department shall not reimburse for both a screening and a screening, brief interven-
4 tion, and referral to treatment provided to a recipient on the same date of service.

5 (5) The following services or activities shall not be covered under this administrative regula-
6 tion:

7 (a) A service provided to:

8 1. A resident of:

9 a. A nursing facility; or

10 b. An intermediate care facility for individuals with an intellectual disability;

11 2. An inmate of a federal, local, or state:

12 a. Jail;

13 b. Detention center; or

14 c. Prison; or

15 3. An individual with an intellectual disability without documentation of an additional psychi-
16 atric diagnosis;

17 (b) Psychiatric or psychological testing for another agency, including a court or school, that
18 does not result in the individual receiving psychiatric intervention or behavioral health therapy
19 from the behavioral health services organization;

20 (c) A consultation or educational service provided to a recipient or to others;

21 (d) A telephone call, an email, a text message, or other electronic contact that is not "face-to-
22 face", unless permitted as a telehealth service pursuant to 907 KAR 3:170 and this administrative
23 regulation;

1 (e) Travel time;

2 (f) A field trip;

3 (g) A recreational activity;

4 (h) A social activity; or

5 (i) A physical exercise activity group.

6 (6)(a) A consultation by one (1) provider or professional with another shall not be covered
7 under this administrative regulation except as established in Section 3(7)(l)1. of this administra-
8 tive regulation.

9 (b) A third party contract shall not be covered under this administrative regulation.

10 (7) A billing supervisor arrangement between a billing supervisor and an approved behavioral
11 health practitioner under supervision shall not violate the supervision rules or policies of the re-
12 spective professional licensure boards governing the billing supervisor and the approved behav-
13 ioral health practitioner under supervision.

14 Section 5. No Duplication of Service. (1) The department shall not reimburse for a service
15 provided to a recipient by more than one (1) provider, of any program in which the service is
16 covered, during the same time period.

17 (2) For example, if a recipient is receiving a behavioral health service from an independent
18 behavioral health provider, the department shall not reimburse for the same service provided to
19 the same recipient during the same time period by a behavioral health services organization.

20 Section 6. Records Maintenance, Documentation, Protection, and Security. (1) A behavioral
21 health services organization shall maintain a current health record for each recipient.

22 (2) A health record shall document each service provided to the recipient including the date of
23 the service and the signature of the individual who provided the service.

- 1 (3) A health record shall:
- 2 (a) Include:
- 3 1. An identification and intake record including:
- 4 a. Name;
- 5 b. Social Security number;
- 6 c. Date of intake;
- 7 d. Home (legal) address;
- 8 e. Health insurance or Medicaid information;
- 9 f. Referral source and address of referral source;
- 10 g. Primary care physician and address;
- 11 h. The reason the individual is seeking help including the presenting problem and diagnosis;
- 12 i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and
- 13 information regarding:
- 14 (i) Where the individual is receiving treatment for the physical health diagnosis; and
- 15 (ii) The physical health provider; and
- 16 j. The name of the informant and any other information deemed necessary by the behavioral
- 17 health services organization to comply with the requirements of:
- 18 (i) This administrative regulation;
- 19 (ii) The behavioral health services organization's licensure board;
- 20 (iii) State law; or
- 21 (iv) Federal law;
- 22 2. Documentation of the:
- 23 a. Screening;

1 b. Assessment if an assessment was performed; and

2 c. Disposition if a disposition was performed;

3 3. A complete history including mental status and previous treatment;

4 4. An identification sheet;

5 5. A consent for treatment sheet that is accurately signed and dated; and

6 6. The individual's stated purpose for seeking services; and

7 (b) Be:

8 1. Maintained in an organized central file;

9 2. Furnished to the:

10 a. Cabinet for Health and Family Services upon request; or

11 b. Managed care organization in which the recipient is enrolled upon request if the recipient is
12 enrolled with a managed care organization;

13 3. Made available for inspection and copying by:

14 a. Cabinet for Health and Family Services' personnel; or

15 b. Personnel of the managed care organization in which the recipient is enrolled if the recipi-
16 ent is enrolled with a managed care organization;

17 4. Readily accessible; and

18 5. Adequate for the purpose of establishing the current treatment modality and progress of the
19 recipient if the recipient received services beyond a screening.

20 (4) Documentation of a screening shall include:

21 (a) Information relative to the individual's stated request for services; and

22 (b) Other stated personal or health concerns if other concerns are stated.

23 (5)(a) A behavioral health services organization's service notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit;
2. Indicate if the service was provided face-to-face or via telehealth; and
3. Describe the:
 - a. Recipient's symptoms or behavior, reaction to treatment, and attitude;
 - b. Therapist's intervention;
 - c. Changes in the plan of care if changes are made; and
 - d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

- a. Clearly display the changes; and
- b. Be initialed and dated by the person who edited the notes.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by an approved behavioral health practitioner under supervision shall be co-signed and dated by the supervising professional within thirty (30) days.

2. If services are provided by an approved behavioral health practitioner under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the approved behavioral health practitioner under supervision concerning the:

- a. Case; and
- b. Supervising professional's evaluation of the services being provided to the recipient.

(6) Immediately following a screening of a recipient, the practitioner shall perform a disposition related to:

- (a) A provisional diagnosis;
- (b) A referral for further consultation and disposition, if applicable; or
- (c)1. If applicable, termination of services and referral to an outside source for further ser-

1 vices; or

2 2. If applicable, termination of services without a referral to further services.

3 (7) Any change to a recipient's plan of care shall be documented, signed, and dated by the
4 rendering practitioner and by the recipient or recipient's representative.

5 (8)(a) Notes regarding services to a recipient shall:

6 1. Be organized in chronological order;

7 2. Be dated;

8 3. Be titled to indicate the service rendered;

9 4. State a starting and ending time for the service; and

10 5. Be recorded and signed by the rendering practitioner and include the professional title (for
11 example, licensed clinical social worker) of the provider.

12 (b) Initials, typed signatures, or stamped signatures shall not be accepted.

13 (c) Telephone contacts, family collateral contacts not covered under this administrative regu-
14 lation, or other non-reimbursable contacts shall:

15 1. Be recorded in the notes; and

16 2. Not be reimbursable.

17 (9)(a) A termination summary shall:

18 1. Be required, upon termination of services, for each recipient who received at least three (3)
19 service visits; and

20 2. Contain a summary of the significant findings and events during the course of treatment in-
21 cluding the:

22 a. Final assessment regarding the progress of the individual toward reaching goals and objec-
23 tives established in the individual's plan of care;

1 b. Final diagnosis of clinical impression; and

2 c. Individual's condition upon termination and disposition.

3 (b) A health record relating to an individual who terminated from receiving services shall be
4 fully completed within ten (10) days following termination.

5 (10) If an individual's case is reopened within ninety (90) days of terminating services for the
6 same or related issue, a reference to the prior case history with a note regarding the interval peri-
7 od shall be acceptable.

8 (11)(a) Except as established in paragraph (b) of this subsection, if a recipient is transferred or
9 referred to a health care facility or other provider for care or treatment, the transferring behavior-
10 al health services organization shall, within ten (10) business days of the transfer or referral,
11 transfer the recipient's records in a manner that complies with the records' use and disclosure re-
12 quirements as established in or required by:

13 1.a. The Health Insurance Portability and Accountability Act;

14 b. 42 U.S.C. 1320d-2 to 1320d-8; and

15 c. 45 C.F.R. Parts 160 and 164; or

16 2.a. 42 U.S.C. 290 ee-3; and

17 b. 42 C.F.R. Part 2.

18 (b) If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric
19 hospital, a psychiatric distinct part unit in an acute care hospital, or an acute care hospital for
20 care or treatment, the transferring behavioral health services organization shall, within forty-
21 eight (48) hours of the transfer or referral, transfer the recipient's records in a manner that com-
22 plies with the records' use and disclosure requirements as established in or required by:

23 1.a. The Health Insurance Portability and Accountability Act;

1 b. 42 U.S.C. 1320d-2 to 1320d-8; and

2 c. 45 C.F.R. Parts 160 and 164; or

3 2.a. 42 U.S.C. 290 ee-3; and

4 b. 42 C.F.R Part 2.

5 (12)(a) If a behavioral health services organization's Medicaid Program participation status
6 changes as a result of voluntarily terminating from the Medicaid Program, involuntarily termi-
7 nating from the Medicaid Program, a licensure suspension, or death of an owner or deaths of
8 owners, the health records of the behavioral health services organization shall:

9 1. Remain the property of the behavioral health services organization; and

10 2. Be subject to the retention requirements established in subsection (13) of this section.

11 (b) A behavioral health services organization shall have a written plan addressing how to
12 maintain health records in the event of death of an owner or deaths of owners.

13 (13)(a) Except as established in paragraph (b) or (c) of this subsection, a behavioral health
14 services organization shall maintain a case record regarding a recipient for at least six (6) years
15 from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

16 (b) After a recipient's death or discharge from services, a provider shall maintain the recipi-
17 ent's record for the longest of the following periods:

18 1. Six (6) years unless the recipient is a minor; or

19 2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority un-
20 der state law.

21 (c) If the Secretary of the United States Department of Health and Human Services requires a
22 longer document retention period than the period referenced in paragraph (a) of this subsec-
23 tion~~[section]~~, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the

1 required period.

2 (14)(a) A behavioral health services organization shall comply with 45 C.F.R. Part 164.

3 (b) All information contained in a health record shall:

4 1. Be treated as confidential;

5 2. Not be disclosed to an unauthorized individual; and

6 3. Be disclosed to an authorized representative of:

7 a. The department; or

8 b. Federal government.

9 (c)1. Upon request, a behavioral health services organization shall provide to an authorized
10 representative of the department or federal government information requested to substantiate:

11 a. Staff notes detailing a service that was rendered;

12 b. The professional who rendered a service; and

13 c. The type of service rendered and any other requested information necessary to determine,
14 on an individual basis, whether the service is reimbursable by the department.

15 2. Failure to provide information required by subparagraph 1. of this paragraph shall result in
16 denial of payment for any service associated with the requested information.

17 Section 8. Medicaid Program Participation Compliance. (1) A behavioral health services or-
18 ganization shall comply with:

19 (a) 907 KAR 1:671;

20 (b) 907 KAR 1:672; and

21 (c) All applicable state and federal laws.

22 (2)(a) If a behavioral health services organization receives any duplicate payment or over-
23 payment from the department, regardless of reason, the behavioral health services organization

1 shall return the payment to the department.

2 (b) Failure to return a payment to the department in accordance with paragraph (a) of this sub-
3 section may be:

4 1. Interpreted to be fraud or abuse; and

5 2. Prosecuted in accordance with applicable federal or state law.

6 (3)(a) When the department makes payment for a covered service and the behavioral health
7 services organization accepts the payment:

8 1. The payment shall be considered payment in full;

9 2. A bill for the same service shall not be given to the recipient; and

10 3. Payment from the recipient for the same service shall not be accepted by the behavioral
11 health services organization.

12 (b)1. A behavioral health services organization may bill a recipient for a service that is not
13 covered by the Kentucky Medicaid Program if the:

14 a. Recipient requests the service; and

15 b. Behavioral health services organization makes the recipient aware in advance of providing
16 the service that the:

17 (i) Recipient is liable for the payment; and

18 (ii) Department is not covering the service.

19 2. If a recipient makes payment for a service in accordance with subparagraph 1. of this para-
20 graph, the:

21 a. Behavioral health services organization shall not bill the department for the service; and

22 b. Department shall not:

23 (i) Be liable for any part of the payment associated with the service; and

1 (ii) Make any payment to the behavioral health services organization regarding the service.

2 (4)(a) A behavioral health services organization shall attest by the behavioral health services
3 organization's staff's or representative's signature that any claim associated with a service is val-
4 id and submitted in good faith.

5 (b) Any claim and substantiating record associated with a service shall be subject to audit by
6 the:

7 1. Department or its designee;

8 2. Cabinet for Health and Family Services, Office of Inspector General, or its designee;

9 3. Kentucky Office of Attorney General or its designee;

10 4. Kentucky Office of the Auditor for Public Accounts or its designee; or

11 5. United States General Accounting Office or its designee.

12 (c) If a behavioral health services organization receives a request from the department to pro-
13 vide a claim, related information, related documentation, or record for auditing purposes, the be-
14 havioral health services organization shall provide the requested information to the department
15 within the timeframe requested by the department.

16 (d)1. All services provided shall be subject to review for recipient or provider abuse.

17 2. Willful abuse by a behavioral health services organization shall result in the suspension or
18 termination of the behavioral health services organization from Medicaid Program participation.

19 Section 9. Third Party Liability. A behavioral health services organization shall comply with
20 KRS 205.622.

21 Section 10. Use of Electronic Signatures. (1) The creation, transmission, storage, and other
22 use of electronic signatures and documents shall comply with the requirements established in
23 KRS 369.101 to 369.120.

1 (2) A behavioral health services organization that chooses to use electronic signatures shall:

2 (a) Develop and implement a written security policy that shall:

3 1. Be adhered to by each of the behavioral health services organization's employees, officers,
4 agents, or contractors;

5 2. Identify each electronic signature for which an individual has access; and

6 3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

7 (b) Develop a consent form that shall:

8 1. Be completed and executed by each individual using an electronic signature;

9 2. Attest to the signature's authenticity; and

10 3. Include a statement indicating that the individual has been notified of his or her responsibil-
11 ity in allowing the use of the electronic signature; and

12 (c) Provide the department, immediately upon request, with:

13 1. A copy of the behavioral health services organization's electronic signature policy;

14 2. The signed consent form; and

15 3. The original filed signature.

16 Section 11. Auditing Authority. The department shall have the authority to audit any:

17 (1) Claim;

18 (2) Medical record; or

19 (3) Documentation associated with any claim or medical record.

20 Section 12. Federal Approval and Federal Financial Participation. The department's coverage
21 of services pursuant to this administrative regulation shall be contingent upon:

22 (1) Receipt of federal financial participation for the coverage; and

23 (2) Centers for Medicare and Medicaid Services' approval for the coverage.

1 Section 13. Appeals. (1) An appeal of an adverse action by the department regarding a service
2 and a recipient who is not enrolled with a managed care organization shall be in accordance with
3 907 KAR 1:563.

4 (2) An appeal of an adverse action by a managed care organization regarding a service and an
5 enrollee shall be in accordance with 907 KAR 17:010.

6 Section 14. Delayed Effective Date. The provisions of this administrative regulation shall be
7 implemented beginning July 1, 2019.

907 KAR 15:022E

REVIEWED:

5/16/19

Date



Carol H. Steckel, Commissioner
Department for Medicaid Services

APPROVED:

6/12/19

Date



Adam M. Meier, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 15:022E

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Chase Coffey, (502) 564-6746, CHFSRegs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by behavioral health services organizations (BHSOs) that focus on substance use disorder treatment. The specific tiers of BHSO referenced within this administrative regulation will focus on outpatient substance use disorder services (BHSO II) and residential substance use disorder services (BHSO III). The licensure for BHSO IIs and IIIs will be determined by the AODE licensure administrative regulations pursuant to 908 KAR 3:170, 3:172, and 3:174. A BHSO is an entity that provides treatment for mental health and substance use disorders and is licensed and regulated by the Office of Inspector General in accordance with 902 KAR 20:430. The array of services includes a screening, an assessment, psychological testing, crisis intervention, mobile crisis services, medication assisted treatment, day treatment, peer support, intensive outpatient program services, individual outpatient therapy, group outpatient therapy, family outpatient therapy, collateral outpatient therapy, partial hospitalization, service planning, and residential services for substance use disorders. In addition, this administrative regulation allows for Medicaid reimbursement for SUD treatment that includes methadone.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with KRS 205.6311, which mandates that Kentucky's Medicaid Program "expand the behavioral health network to allow providers to provide services within their licensure category." In addition, this administrative regulation will assist with the implementation of an approved SUD 1115 Waiver that is part of the Kentucky HEALTH 1115 Waiver.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by expanding "the behavioral health network to allow providers to provide services within their licensure category."

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The administrative regulation will assist in the effective administration of the authorizing statutes by tiering BHSOs according to the licensure and type of services provided. In addition, new practitioners are included throughout the tiers to provide services to help meet recipient demand. Finally, the provisions will assist with conforming to the content of KRS 205.6311(2).

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Entities licensed as alcohol or other drug treatment entities and as behavioral health services organizations will be affected by this administrative regulation as a need for dual licensure will be removed. Medicaid recipients in need of substance use treatment, mental health treatment, or treatment for co-occurring disorders will also be affected by this administrative regulation. Currently, there are 1.4 million Medicaid members. DMS anticipates that up to seven (7) percent of the Medicaid population could seek OUD treatment.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Providers that plan to provide SUD or co-occurring disorder treatment services in a BHSO setting will need to attain AODE inpatient or outpatient licensure and ensure that the appropriate services are provided by the appropriate provider within each tier of facility. There are currently 11 narcotic treatment programs enrolled in Kentucky as Medicaid providers. There are currently 134 enrolled BHSOs.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Entities will need to qualify for and attain AODE inpatient or outpatient licensure as appropriate.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). This administrative regulation will allow access to a full continuum of care for substance use disorder services. Any Medicaid recipient in need of substance use disorder services will have access to SUD services that are provided by a facility with appropriate licensure. Currently there are 1.4 million Kentuckians receiving Medicaid services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS currently performs many of the functions in this administrative regulation. DMS will be expanding coverage of methadone as a part of this administrative regulation. DMS may cover as many as 4,000 Medicaid eligible members. Methadone coverage may cost as much as \$8000 per year per member, however, this will not be a hydraulic price increase because at least ninety-five (95) percent of the impacted individuals are within managed care.

(b) On a continuing basis: DMS anticipates that methadone coverage will continue for certain Medicaid members at a cost of \$8000 per year per member. DMS may cover as many as 4,000 Medicaid eligible members. Methadone coverage may cost as much as \$8000 per year per member, however, this will not be a hydraulic price increase because at least ninety-five (95) percent of the impacted individuals are within managed care.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and en-

forcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied in that established types of services are now grouped by licensure and whether the service is for substance use disorder or mental health treatment. However, the requirements within each tier of service are applied equally to all entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 907 KAR 15:022E

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; or Chase Coffey, (502) 564-6746, CHFSRegs@ky.gov.

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 18022(b)(1)(E), 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Substance use disorder services are federally mandated for Medicaid programs. 42 U.S.C. 18022(b)(1)(E) mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency that oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid). Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation #: 907 KAR 15:022E

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; or Chase Coffey, (502) 564-6746, CHFSRegs@ky.gov.

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this new administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The new administrative regulation is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The new administrative regulation is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS will be expanding coverage of methadone as a part of this administrative regulation. DMS may cover as many as 4,000 Medicaid eligible members. Methadone coverage may cost as much as \$8000 per year per member, however, this will not be a hydraulic price increase because at least ninety-five (95) percent of the impacted individuals are within managed care. Furthermore, DMS does not expect any additional costs in administering this new administrative regulation during the first year due to program enhancements and IT infrastructure upgrades.

(d) How much will it cost to administer this program for subsequent years? DMS will be expanding coverage of methadone as a part of this administrative regulation. DMS may cover as many as 4,000 Medicaid eligible members. Methadone coverage may cost as much as \$8000 per year per member, however, this will not be a hydraulic price increase because at least ninety-five (95) percent of the impacted individuals are within managed care. Furthermore, DMS does not expect any additional costs in administering this new administrative regulation during subsequent years due to program enhancements and IT infrastructure upgrades.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

